Art in hospitals: does it work? A survey of evaluation of arts projects in the NHS

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Introduction

The arts have long been associated with hospitals, but a new importance is currently attached to their contribution to health. Efforts are being made to evaluate and identify benefits. This is a qualitative rather than quantitative process, and most research relates to the use of the arts in mental health facilities or elderly care, although there is some evidence that benefits can be perceived in the acute sector.

The literature on the subject is slight. There are various works giving anecdotal information, but very few controlled studies. Unpublished conference papers include remarks about elderly patients using lavatories less frequently during art sessions, and so forth, but there is no collation or organization of such material. Pilot evaluations have been carried out in two hospitals in the North of England. (Northern Regional Health Authority funded researchers at Earls House Hospital, Durham and Prudhoe Hospital, to identify the outcomes of arts projects in 1991-1992: the reports are unpublished.) This paper deals with a third at a mental handicap hospital in Scotland. One published paper by Roger Ulrich[1] shows measured benefits of landscape for surgical patients. Another by Marvin Gewirtz[2] briefly outlines benefits of longevity, health and sociability for elderly people involved in an oil painting class in New York.

Research may be scant, but activity is growing and inherits a long but interrupted tradition. The idea of art in hospitals is associated with precedents such as Brunelleschi's Foundlings Hospital in Florence, although that was in modern terms an orphanage. In England, the earliest site-specific hospital murals are by Hogarth at St Bartholomew's, London, and remain in their original location on the stairs to the Great Hall. A more recent work depicting Grecian athletes was whitewashed by order of the Hospital Administrator on the grounds that the parents of girls seeking nursing training might question the ethos of a hospital in which paintings of naked male figures were displayed. Presumably anatomical drawings do not come under the same heading, and the incident reflects a culture in which art is marginal and architecture sometimes regarded as a sufficient presence of the aesthetic, without ornament. The perceived poverty of many post-war hospital buildings result from just such a functionalist approach, epitomized by Northwick Park Hospital, Harrow. At many National Health Service (NHS) hospitals, however, arts projects now flourish, and most are concerned with the visual arts and crafts, using media such as painting, printmaking, sculpture, textiles, ceramics and stained or etched glass. Art was included in the brief for a series of National Demonstration Projects funded by the Department of Health for refurbishing outpatient, accident and day case departments in around 20 general hospitals throughout England between 1989 and 1992. Some new hospitals, such as West Dorset, in Dorchester, and the General Infirmary at Leeds, have planned for art in new buildings, where artists and architects can collaborate; others, such as the Royal Sussex County Hospital, in Brighton, have a policy to include art in major upgrading schemes. In 1989 a national organization, British Health Care Arts, chaired by Dr J H Baron, and advised by architects within the Department of Health, was established to provide consultancy to hospitals wishing to include art in their environment.

The rapid growth of activity in recent years suggests it is now more important and urgent to ask whether hospital art projects work, and in whose terms. Much art in the NHS used to be 'cheap and cheerful', or a cosmetic solution to bad buildings. More innovative approaches have identified art as a visible aspect of quality care and a way to lend a hospital a sense of local identity. Within the context of various quality initiatives, it is vital that any art introduced into NHS buildings is of a high quality of imagination and skill, and appropriate to its setting and relevant user groups. To assess the extent to which art has quality requires the expertise of arts professionals. The extent to which there are measurable benefits to patients and staff is another question and requires considerably more research than has yet been undertaken, and the collaboration of arts professionals with care staff and environmental psychologists.

Art and clinical care

Ulrich's paper of 1984[1] established that a view of trees and landscape aided recovery from surgery. His study, from medical records over 9 years (1972-1981), compared patients in one ward, some of whom looked out onto trees, others onto a brick wall. The 'tree' group recovered from cholecystectomy on average in 7.96 days, and the 'wall' group in 8.70 days. Strong and moderate doses of analgesics were reduced significantly in days 2 to 7 after surgery. This suggests that an environmental factor, in this case landscape, caused the difference, since all other factors were controlled. It may be speculated that, if one environmental factor can achieve this, so can others, such as art and music. However, the choice of art is important, and relates to cultural climates and expectations; later research by Ulrich showed negative patient reactions to modern abstract art.

Views of 'nature' may not be the only things to influence recovery. Yet there is a long tradition in Western society that contact with 'nature' in the form of views or pictures, or written descriptions or musical evocations, of landscape does have a broadly therapeutic

effect. This may be in reaction to urbanization and a romanticization of the 'countryside'. However, some research on landscape confirms that 'certain mental disorders can be influenced by environmental factors' which include landscape and buildings[3].

More studies are required on recovery rates in different environments, and particularly before and after refurbishment in which art and interior design are combined. It will always be difficult to separate the effects of art from those of interior design, and it makes no sense to hang beautiful pictures in awful spaces. Little information is available on the direct effects of factors such as ward design on either the quality of life or response to treatment. A recent study relating to elderly care in London hospitals showed that patients transferred from a disused building to refurbished wards responded better than those put in a new building, but the two groups were not matched by dependency and the results are not conclusive[4].

In the field of mental health, covering both mental illness and handicap, it may be easier to carry out controlled studies. In acute hospitals it is difficult to do this, since the majority of those treated are outpatients or attend the accident and emergency department. For them, the appearance of waiting and reception areas will be important, but recovery may not be affected directly. Art does not set broken bones; it helps patients relax and feel welcomed. In day case departments, a 'hotel' style is required and the new Building Note on the subject will specify the inclusion of art; but this will not affect the recovery rates of patients who in any case return home after a few hours. In mental health hospitals, residents and patients have individual care plans which are monitored by care staff. These often and obviously include items such as the gaining or regaining of self-esteem, communication skills, controlled mobility, and sensory stimulation. All art involves these.

If a project is to be evaluated, this can be done only against stated aims and objectives, and in the mental health sector, these should relate to care plans. Staff who monitor these plans can then be involved in evaluating any differences which are evident after the establishment of an arts project.

In mental health hospitals the need is more for art activity than art as object. Residents and patients can take part in art projects led by professional artists, and the artist is there as a catalyst to the creativity of residents and patients more than to make her/his own work. An attractive environment is helpful, and a setting for art made in such projects. Making a picture or a pot, or a mosaic or banner, involves a whole set of choices, of colour, placing, texture, size and direction, achieved through controlled mobility of hand, co-ordinated with eye and brain. Seeing the finished work and showing it to others involves a sense of satisfaction and self worth as well as being a form of communication. This is distinct from the use of art in psychotherapy, where all images are interpreted. We are concerned here with making art, not outcomes such as the clinical insight into mental disorders, nor with value judgements on 'good' or 'bad' art made by non-professional artists.

Strathmartine Hospital, Dundee

Strathmartine Hospital in Dundee is a mental handicap hospital with about 200 residents (reduced from about 400), many of whom exhibit challenging behaviour or are heavily dependent on care. An artist in residence, Lucy Byatt, worked for 18 months until May 1992. The length of the residency reflected the need for a period of induction and need for the artist to slowly build relationships with residents and staff. The project was 50% funded by the hospital from a legacy, and 50% by the Scottish Arts Council. It was initiated and managed by British Health Care Arts, who carried out a study of its effectiveness. This is not a controlled study, in that this client group is not compared with another control group deprived of art. The ethics of controlled studies are in some cases problematic if deprivation of the control group is involved, whilst voluntary deprivation tends to mean the control group are, because self-selected, different in some way such as outlook.

Figure 1. Alfie and Effie *sculpture by residents at Strathmartine Hospital*

At the end of the residency, marked by a joint exhibition of work by the artist in residence and hospital residents at the local art gallery, a study of staff feedback was undertaken. Two researchers carried out one to one interviews with 20 staff who had been directly involved, using a common set of questions. The use of a questionnaire alone was felt impersonal and likely to be ignored by a proportion of staff. Since the sample was quite small it was important that all took part.

One set of questions concerned the initial impact of the project. Only one in 20 gained information from the 'official' note circulated, and eight received none by any route. However, once contact was made, 10 formed a 'very positive' view and only one 'negative'. The personality of the artist, refreshing and lively, and with good communication skills, seemed the key factor. One answer was that 'Anything new coming into the ward is a good thing'; another that 'experiences with the world outside . . . are beneficial'.

As to whether the artist fitted into the daily routine, about half saw no problems and the other half thought problems were eventually overcome, suggesting that induction periods need to be quite long. The artist was seen to form a link between nursing and therapy staff.

Twelve of the staff were involved in a project on a ward for people with challenging behaviour. This produced an environment adorned with sculptures made in wire and paper, using natural and artificial light. At first, sensory stimulation was emphasized through colour and the texture of materials. Seven staff were involved in a project for an exhibition of art by residents in a shopping centre, and six were involved in a project to make large and colourful metal flowers for a garden wall. A number of smaller projects involved the artist working with single members of staff. Several staff were involved in more than one project. The pattern of activity was continuous, indicating that staff

interest was sustained and spread through different activities, some involving community links. It is difficult to make a value judgement as to whether such projects 'work', but simply to make community links is not easy for mental handicap institutions, and the arts were seen here to be an effective and non-contentious vehicle.

Part of the stated aim of the residency was that the artist would work with staff to extend their skill base. Thirteen said their 'confidence to experiment in [their] daily work' had increased through working with the artist. Comments included that the artist had 'given me the confidence to choose pictures for the corridor which is something I would never have done in the past'. This suggests arts projects can at least help staff make the independent choices they encourage residents to make! New skills acquired by staff fell into three groups: communication; making art; other. One commented: 'I learned the art of diplomacy and how to cope with situations'; another: 'I learned how to think laterally'. In the 'other' category, one commented: 'I learned how to think through projects'; another: 'I'm not an arty person so I never realized before now how art can have an effect on people with behavioural problems'. Compared with the art skills, of working with simple and inexpensive materials such as tissue paper, the communication and other aspects reported by staff seem to contribute to a more imaginative culture in the institution.

Asked whether 'the residency has affected the delivery of care at Strathmartine?', 11 said a clear 'yes', and three a clear 'no'. In particular, the creative abilities of residents were more recognized and quality of life seen to improve, especially on the challenging behaviour ward. Fifteen people said the environment had been affected, with descriptions such as 'more pleasing, stimulating and calming'. Fifteen people said they would like to see another residency, though this might involve either a visual or performing artist.

Amongst comments recorded but not related directly to the structured questions were:

'working with an artist in residence has been beneficial to the clients. They have learnt new skills and it is good to be involved with someone who is not driven by the Health Service'

and 'personally I found it character building'. The majority of impressions were positive, and negative comments tended to relate to conflicts over resources at a time of budget reductions to match a move of residents into the community.

The general implications of this study, which remains at an anecdotal rather than scientific level, are that planning and integration are important, with an induction period during which the artist and staff form links and common understanding; that it takes time to build a relationship with clients; that an artist can seed attitudes (like lateral thinking) as much as skills; and that the creative abilities of staff and residents can be recognized and have outcomes including making independent choices.

This study did not include interviews with residents, but these should be carried out in evaluations of art projects in mental illness facilities. A report by the Kings Fund[5] shows this can be done and that refurbishment and decorative detailing does produce positive comment. Not all cultural factors are perceived positively - one respondent in this survey said 'ward life is governed by TV and radio'. A newly decorated day room was described as 'splendid room like a hotel', and 'wonderfully improved'. Mentally ill patients have also been seen by staff to respond well to working with an artist. A charge nurse at a Scottish hospital wrote, after a 1 year residency by a sculptor, that

the benefits gained by patients . . . were so considerable that it was acknowledged that this pioneering activity had to continue[6].

Conclusions

So, does art in a hospital work? If the question is defined in terms of assisting the delivery of care plans in mental health, the anecdotal studies so far conducted suggest the answer is yes, as perceived by staff. Comparative studies are required between institutions with and without arts projects, and in which evaluation takes place continuously, through shadowing of the project by a researcher. In terms of acute care, only Ulrich's paper shows hard data on reducing recovery times through an environmental factor, and more studies are required. There is as yet no generally agreed methodology for this, and it would be difficult (and pointless) to separate art and design. The new NHS culture tends to support an integration of art, architecture, interior design and landscape design, and it is the combined effects of all these environmental factors which should be measured, in terms of patient response and relaxation, reduction of non-attendance rates in clinics, ease of staff recruitment and retention, and reduction of longer term maintenance costs.

A new publication[7] shows 12 case studies where good design in all aspects has been combined with improved systems of giving care in various departments of an acute hospital. A pilot study at the University of Washington, Seattle, is studying the work of the 'bedside artist', and uses a framework developed between market researchers, arts professionals and social psychologists; its findings will be disseminated through the Society of Healthcare Arts Administrators.

Much remains to be done, but initial indications are that studies can be devised, will require funding, and may assist in developing arts projects which better meet the needs of patients and staff. Obviously, an attractive building with pleasant landscaping, and art or craft works used to give special identity to spaces, will be more welcoming and enjoyable than a bleak institutional block. Equally, the option to make art or craft works will add a dimension to institutional life. The next step is to demonstrate it.

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